PERSONNEL CABINET
ENROLLMENT INFORMATION BRANCH
HEALTH INSURANCE TRANSMITTAL LOG

DATE SHIPPED: ____/____/____ COMPANY NUMBER: _____ AGENCY NAME: _____

SENT **RECEIVED**

LAST NAME	SSN	APPL	CONT	FSA	OTHER	APPL	CONT	FSA	OTHER	COMMENTS

DATE RECEIVED: _____/_____/_____ RECEIVED BY: _____

Insurance Coordinators must mail 2 copies of this form to DEI.